Waterloo Wellington **LHIN**

COMMUNITY REPORT 2014-15

Ontario
Local Health Integration Network

OUR **MISSION** IS:

To lead a high-quality integrated health system for our **residents**.

OUR **VISION** IS:

Better Health – Better **Futures**.

OUR **CORE VALUE** IS:

Acting in the **best** interest of our **residents'** health and well-being.

LOCAL SOLUTIONS – FOR YOU AND YOUR FAMILY

Acting in the best interest of our residents' health and well-being is our core value and the principle that guides the work we do each and every day. Building a high quality, integrated local health system requires a deep understanding of the health needs of our community and partnership with local health service providers, governors and community leaders from across many sectors.

Our efforts are focused on improving your health and well-being, and it is working. We know this because you have told us that your care is better coordinated and you have more confidence in the local health system. In fact, in a recent survey, 85 per cent of Waterloo Wellington residents rated their personal health care experience as good, very good or excellent. Performance data tells us that you are waiting less time for care in the Emergency Department and for elective surgeries and that quality has improved in a range of different clinical areas. Physicians tell us they have more timely access to information about your care than ever before. And you tell us you have improved access to care at home for the ones you love.

In the pages ahead, we provide an overview of some of the key improvements that have been made in our local health system. We have included in our Community Report stories from our residents. We share their experiences because they help us identify where the system is working well, and where it needs improving.

Together, with our partners in other sectors, we are helping to make Waterloo Wellington a healthier, more vibrant place to work and live. We will continue to ask what is most important to you, make advancements and report on results. We are here to listen and to act and we encourage you to contact us to provide feedback, share a story or offer suggestions for further improvement of your health system.

Joan Fisk
Chair, Board of Directors

Bruce Lauckner
CEO

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WHY LOCAL IS SO IMPORTANT

No one knows better what is needed for our community than those of us who live here, work here and receive health care here. That doesn't mean we can't learn from others. What it does mean is that solutions need to be tailored to fit the unique needs of Waterloo Wellington.

The Waterloo Wellington area is 90 per cent rural, yet almost 90 per cent of our residents live in urban areas. We have a growing high-tech hub, four internationally recognized post-secondary institutions, a nationally famous farmers' market and thriving agricultural industry, a vibrant arts and theatre community from Drayton to Guelph and beyond, and much, much more. Our diverse population includes French-speaking, Aboriginal, Mennonite, and immigrant residents. While we have increasing education rates, we also have concentrated areas of poverty.

The medical and business professionals who work at the Waterloo Wellington LHIN understand our community because they are local. Our children play sports and go to school together. We shop at the same grocery stores, we celebrate at the same festivals, and when we need medical care, we go to the same hospitals, doctors, and clinics. We meet at the same libraries and community centres, and we interact with many of the same service organizations as volunteers or clients. The doctors who work at the Waterloo Wellington LHIN literally work with us and their patients in the same day.

As local residents, we are here to support providers as they collaborate to make improvements each and every day. When necessary, we intervene to ensure the decisions that are made are in the best interest of residents. We also lead the creation of programs that increase quality and ensure consistent levels of care across the entire health system. These are improvements that benefit us all.

Most importantly, we interact regularly with the residents who contact our office, and we formally engage our community to get their input and feedback. The changes made to improve local health are based on the input of local residents and local health care workers. They are also grounded in best practice and aligned with provincial strategy and vision.

This is the benefit of being local: knowing the needs of our community, seeing the system view and where pieces need to be better connected, and leading local solutions that will improve the health of those around us.

WWLHIN's TOTAL POPULATION

778,676

SENIORS (65 YEARS & OLDER)

14.3%

ABORIGINAL POPULATION

1.4%

RURAL AREA POPULATION

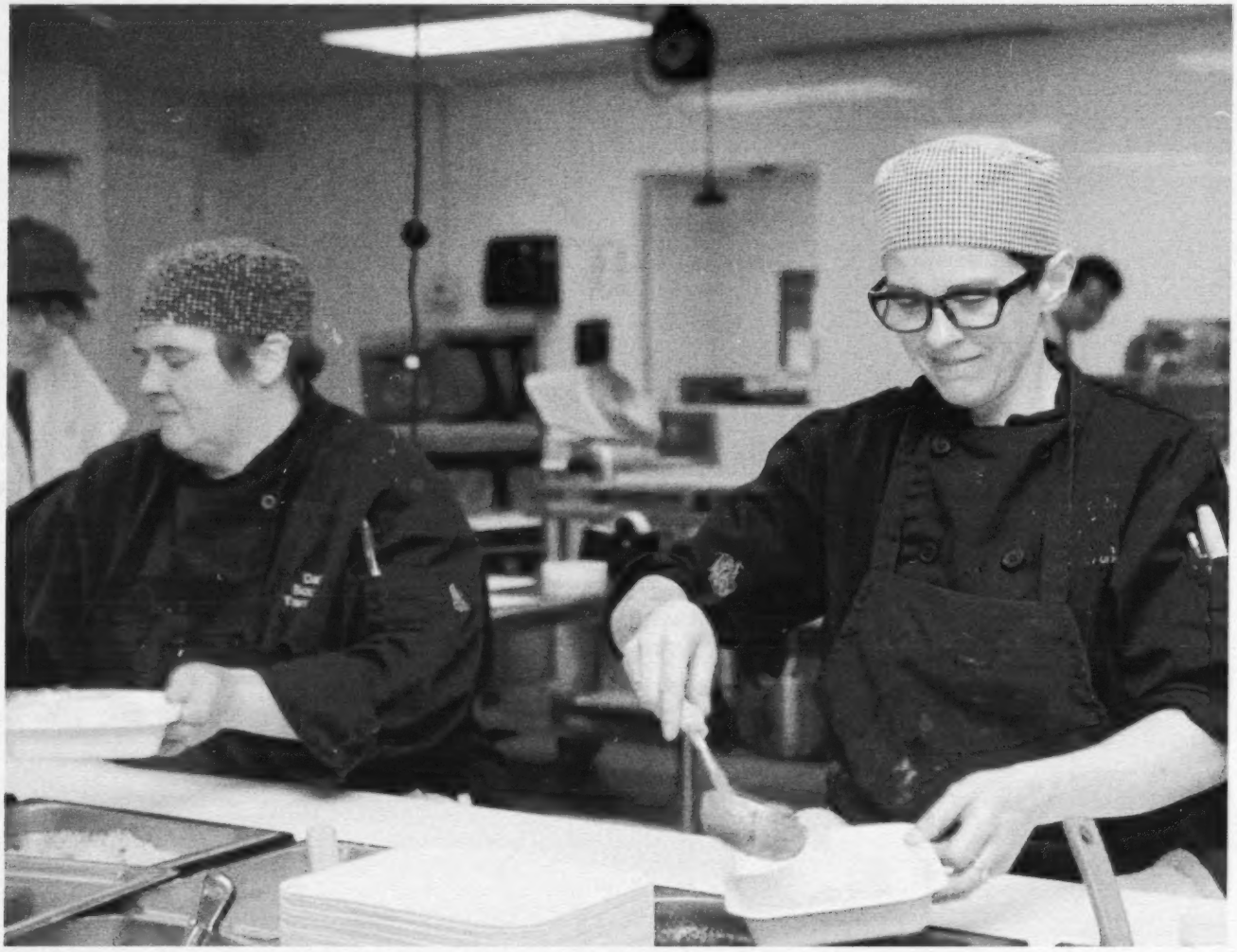
11%

LIFE EXPECTANCY AT BIRTH

81.8 YEARS

IMMIGRANT POPULATION

20.6%



COLLABORATION: IMPROVING HEALTH, TOGETHER

There are many things, in addition to health care services, that contribute to our overall health and well-being. There are called the "social determinants of health." Education, employment, income, housing and many other factors play a role in determining how healthy we are now and what our health needs may be in the future.

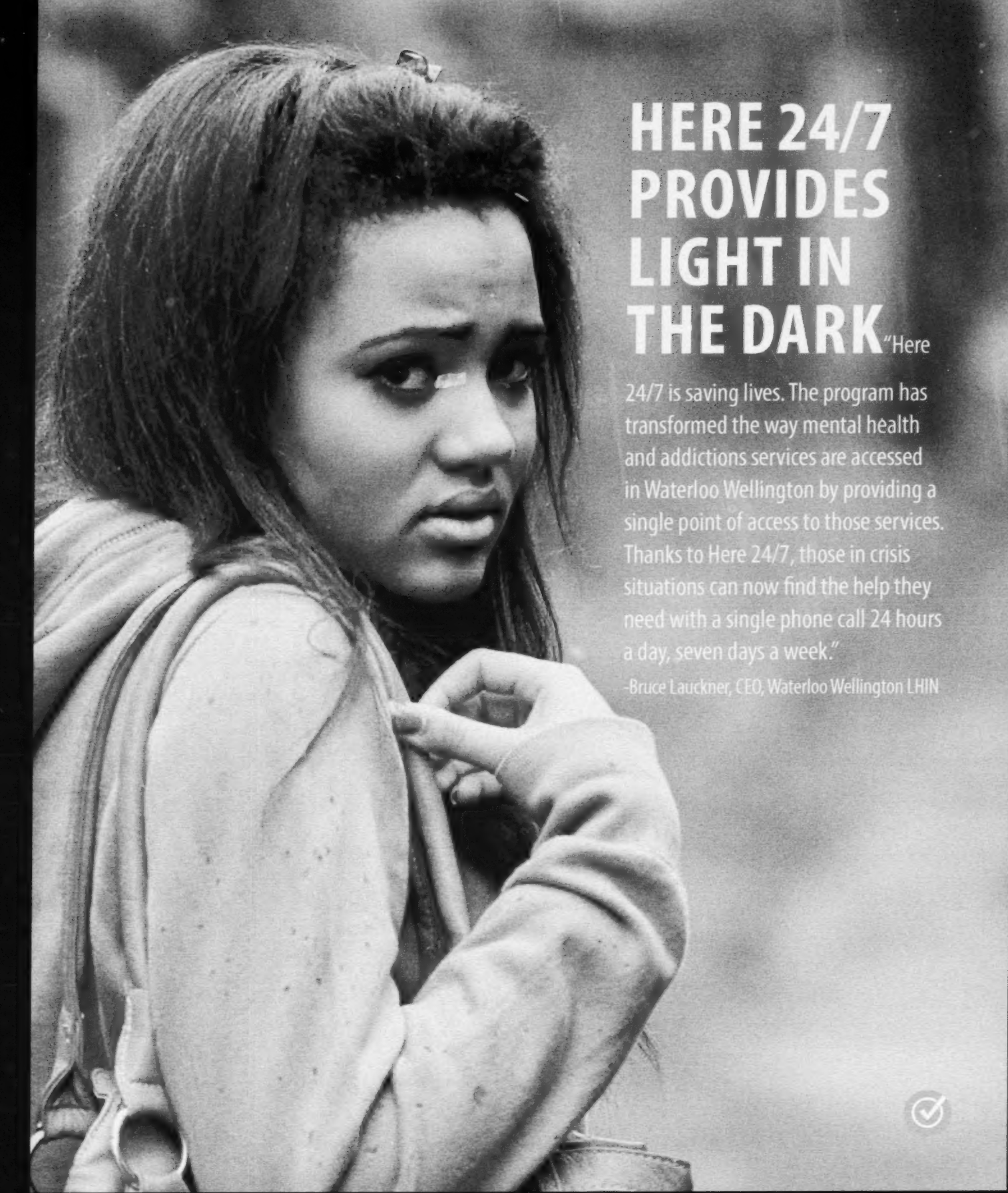
That is why the LHIN works with the entire community to set priorities and take action on initiatives that will create the important improvements in the health system that our residents deserve.

This year's Annual Report demonstrates how, through collaboration and partnership with residents, health service providers, governors and community leaders, we have been able to make improvements within three priority areas:

- Enhancing Access to Primary Care
- Creating a More Seamless and Coordinated Health Care Experience
- Leading a Quality Health Care System Using Evidence Based Practice

STORIES

Our Community Report celebrates the successes of the health system through the experiences of the residents of Waterloo Wellington. In this section of the report, you will find real stories from people who live in Waterloo Wellington. These stories are representative of the ones we hear each and every day. They inspire and motivate the staff at the Waterloo Wellington LHIN to continue improving – challenging – and transforming the current system.


HERE 24/7 PROVIDES LIGHT IN THE DARK
"Here 24/7 is saving lives. The program has transformed the way mental health and addictions services are accessed in Waterloo Wellington by providing a single point of access to those services. Thanks to Here 24/7, those in crisis situations can now find the help they need with a single phone call 24 hours a day, seven days a week."
-Bruce Lauckner, CEO, Waterloo Wellington LHIN

REACHING OUT & FINDING HELP: KOURTNEY'S STORY

Kourtney was in crisis. She hid herself in the girl's washroom at her high school. Eight months of bullying was taking its toll. Now she was sitting in the stall thinking about taking her life.

She had already made a few attempts to commit suicide before. Her wrists showed the faint evidence of her previous attempts.

Sitting alone in the bathroom stall, she made a decision to seek help.

Not knowing where else to turn, Kourtney reached out to the guidance counsellor at her school.

One look at Kourtney and her counsellor, Randall, knew he needed to get her help right away. It was a matter of life or death.

Randall knew of the Here 24/7 service and with Kourtney in his office, he placed the call.

"When I talked with Kourtney I knew I had very little time to act to save this young girl's life. I called the number and it was answered right away. Kourtney and the service coordinator talked at length. Then the service coordinator followed up by coming to the school to help Kourtney get the supports she needed."

It became apparent in conversations with the service coordinator at Here 24/7 that depression from bullying was only one symptom of a larger mental health concern. Kourtney had turned to drugs and alcohol as a coping mechanism and became addicted to the prescription pain medication her mother used.

Through her service coordinator, Kourtney was connected to an addictions counsellor who helped her manage her addiction. She also now has regular sessions with her guidance counsellor at school who is helping her cope with the bullying and to prepare for post-secondary studies.

Today, Kourtney is feeling healthier and more like herself. She has, with help and support, begun to rebuild her young life. She knows she can always call Here 24/7 anytime she feels like she needs extra support.

Kourtney: "The distress line was a true life saver. I will be forever grateful to everyone for helping me when I needed them."

ONE CALL: that's all it takes for someone who is in crisis to get the help and supports they need when and where they need it.

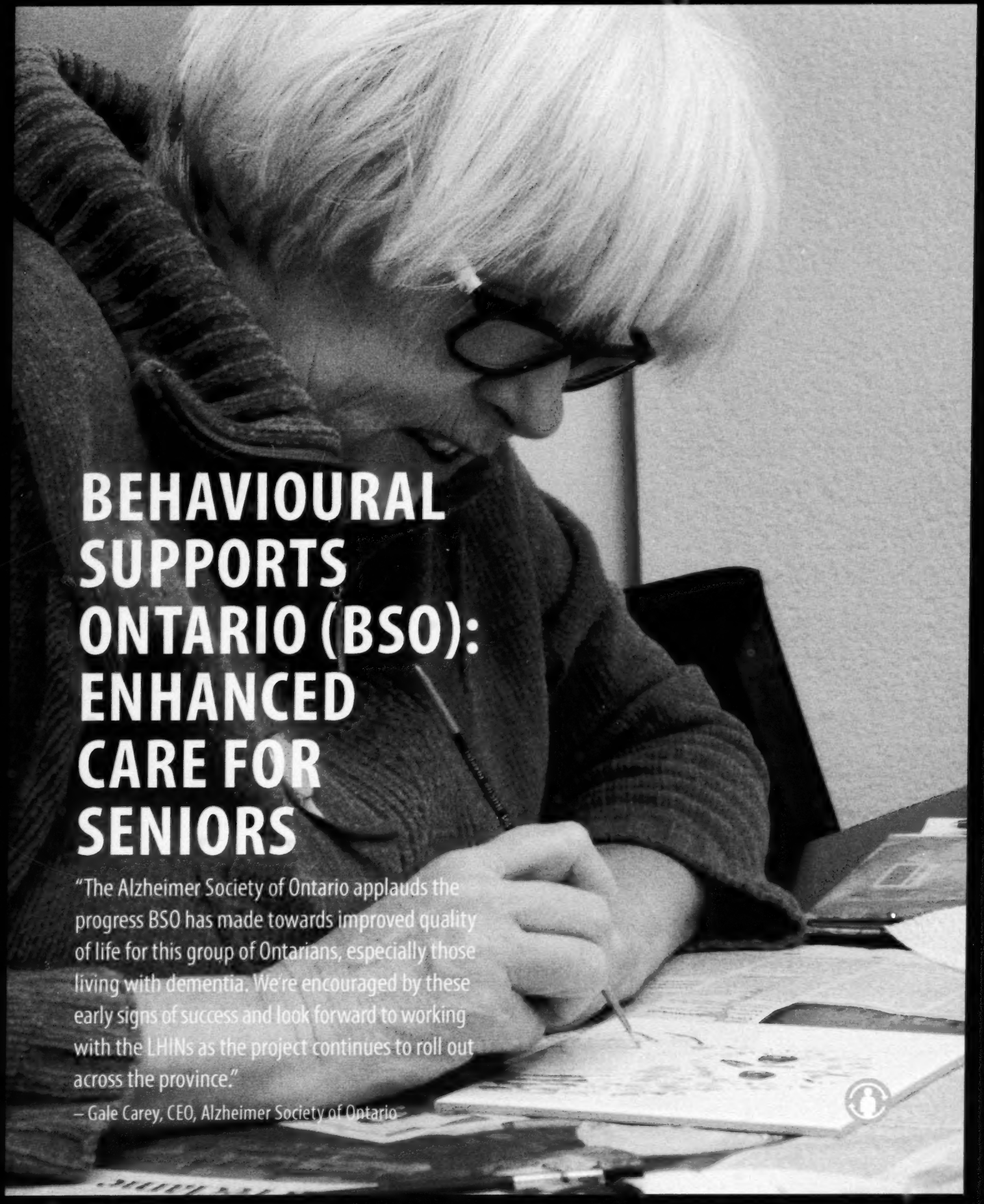
Working with any of the 12 partner agencies that provide services for addictions, mental health or crisis support in Waterloo Wellington, Here 24/7 is able to provide residents a coordinated and collaborative approach to mental health and addictions services 24 hours a day, 7 days a week – a first for Ontario.

When a resident contacts Here 24/7, staff, trained to provide assessments, will match them with the service options available or will link them to services and supports within the community.

For most services, staff have the ability to schedule appointments directly with each partner agency so the resident does not need to re-tell their story.

MORE THAN 11,500 PEOPLE WERE SERVED THROUGH "HERE 24/7" IN THE FIRST YEAR

YouTube
Check out Joseph's story online: TheWWLHIN



BEHAVIOURAL SUPPORTS ONTARIO (BSO): ENHANCED CARE FOR SENIORS

"The Alzheimer Society of Ontario applauds the progress BSO has made towards improved quality of life for this group of Ontarians, especially those living with dementia. We're encouraged by these early signs of success and look forward to working with the LHINs as the project continues to roll out across the province."

– Gale Carey, CEO, Alzheimer Society of Ontario

REGAINING INDEPENDENCE: NOREEN'S STORY

There was a time, not too long ago, when Noreen's life was upside down.

Just into her 60's, she began to experience memory loss and frequently felt agitated and confused. As a few years passed, Noreen's struggles increased. She began having a hard time in social situations and could no longer keep up with conversations. She became more and more isolated. Noreen was very social and the isolation caused her to become depressed. She also experienced increased difficultly caring for herself.

In her confusion, she would often visit the emergency department unnecessarily.

After one of her emergency department visits, Noreen was diagnosed with dementia and was referred to the Community Care Access Centre (CCAC) for assessment and support.

Along with her daughter, CCAC Care Coordinator and Geriatric Emergency Management (GEM) Nurse it was determined the most supportive setting for Noreen would be a long-term care home in Fergus.

Noreen's team worked hard to ensure the transition was as seamless as possible for Noreen, however, the stress of the change and perceived loss of independence caused Noreen to become even more agitated. She started resisting care from her caregivers.

Staff at the long-term care facility called on the support of the Behavioural Supports Ontario (BSO) team to assist them in helping Noreen manage the responsive behaviours caused by her dementia.

BSO is a provincial initiative, funded through the LHINs, that focuses on providing specialized care for those diagnosed with behavioural issues that are caused by conditions like Alzheimer's disease and other forms of dementia.

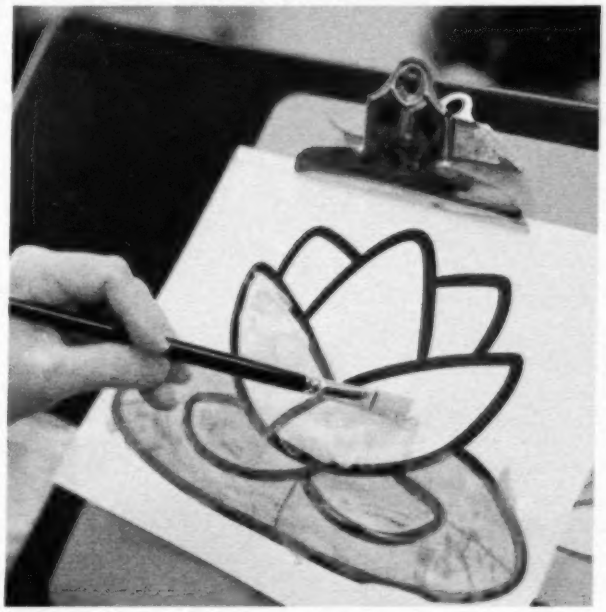
The team worked in collaboration with Noreen to identify areas of support. She had three goals: maintain her mood, improve her social life and regain some of her independence.

To help Noreen achieve her goals, the BSO team implemented Montessori techniques - the use of repetitive tasks and recreation therapy to help dementia patients keep their minds active.

The BSO team also coached staff on how to use validation techniques to calm Noreen when she was anxious and gave tips on how to provide a supportive rather than a "do for" approach to help her remain as independent as possible.

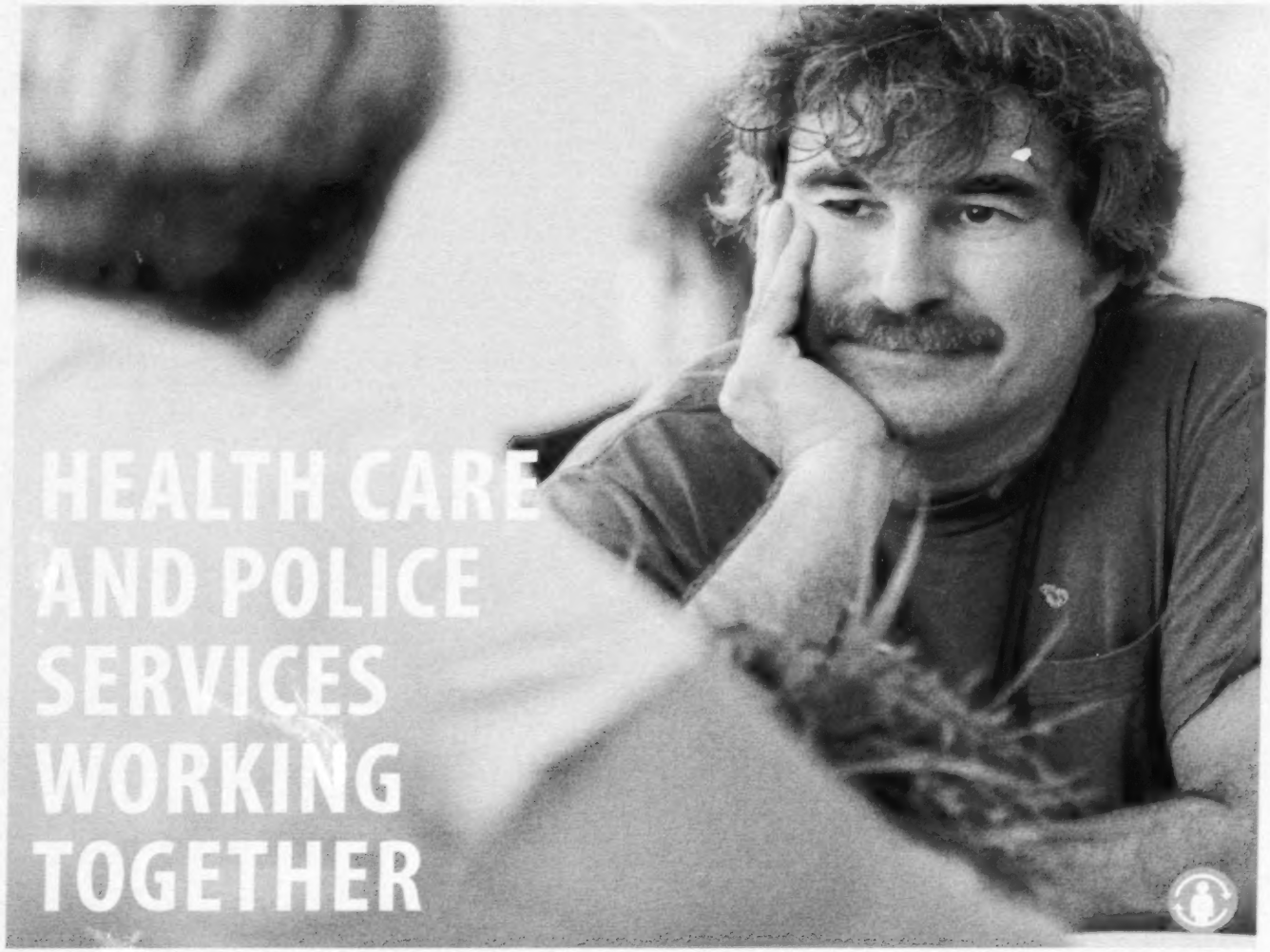
To improve her social life and manage her anxiety, the team encouraged Noreen to engage in activities she enjoyed. Noreen used to be a painter and was especially fond of doves so, as part of a group art class, she began to paint them. This activity brought joy and relief from her depression and anxiety.

Noreen's transition to long-term care went very well and thanks to the extra support from the BSO team, she has settled into the routine of her new home. Noreen paints every chance she gets and her family is especially grateful to see her be able to enjoy the things she used to do.



THE BSO PROGRAM IN WATERLOO WELLINGTON HAS BEEN

RECOGNIZED PROVINCIALLY AS A LEADING PROGRAM IN BEHAVIOR SUPPORT SERVICES IN LONG-TERM CARE



HEALTH CARE AND POLICE SERVICES WORKING TOGETHER

IT BEGAN SEVERAL YEARS AGO WHEN THE WATERLOO WELLINGTON LHIN ASKED A LOCAL CHIEF OF POLICE:

"What's the one thing we could do to help the police?"

HIS ANSWER WAS SIMPLY:

"Put mental health nurses in my cars."

In response to that request, the Waterloo Wellington LHIN Board of Directors invested in an exciting new partnership with the Waterloo Regional Police Service and the local Canadian Mental Health Association (CMHA-WWD) to create a Specialized Mobile Crisis Team (SCT). The program works like this: addictions and mental health experts join police officers responding to emergency calls and provide support or referrals on the spot. As a result, unnecessary emergency department visits are prevented, police are spending less time on calls, residents struggling with addictions or mental health issues are getting better care faster and these residents are less likely to find themselves in conflict with the law.

In October 2014, the Waterloo Wellington LHIN Board of Directors decided to expand the program into both the City of Guelph and in Wellington County through the Ontario Provincial Police. With this investment, the new initiative, called Integrated Mobile Police and Crisis Teams or IMPaCT, was rolled out. Now residents across the Waterloo Wellington LHIN will have access to a joint partnership with police and mental health professionals to provide more clinically informed care, resulting in fewer trips to the Emergency Department, and better outcomes for people in crisis.

POLICE AND MENTAL HEALTH WORKING TOGETHER: LUKE'S STORY

Patty felt frightened and didn't know where to turn. It was a hot night in July and her husband, Luke, was angry and talking about wanting to kill himself. Patty felt concerned for his safety and that of her two teenage children: Mike and Lana. So she called 911. Within minutes, police officers arrived at the residence along with a mental health nurse, who is part of the Specialized Crisis Team (SCT).

The mental health nurse, Rosa, quickly assessed the situation. Her first priority was to make sure the children were okay and felt safe. Then she talked to Luke to calm him down. Once she and the officers were satisfied there was no immediate danger to the family, Rosa took charge of the situation so the police officers could be freed to take other emergency calls.

Rosa continued to talk with Patty and Luke. Together, they created a safety plan that would get the family through the rest of the night and into the next day.

Rosa learned that Luke was a truck driver and had developed a fear of crashing his truck. The fear had become so debilitating that it prevented him from working. Patty was seasonally employed so there was no steady income. This meant that the family's financial situation had become dire. They were behind in their bills and were facing eviction from their home. Food was scarce and the family was in poor health. The situation had become unbearable to Luke. He felt taking his own life was the only answer.

The next day, Rosa connected the family to a mental health coordinator. She worked with Luke to arrange an appointment with a psychiatrist to help him cope with his mental health concerns and anxiety around crashing his truck.

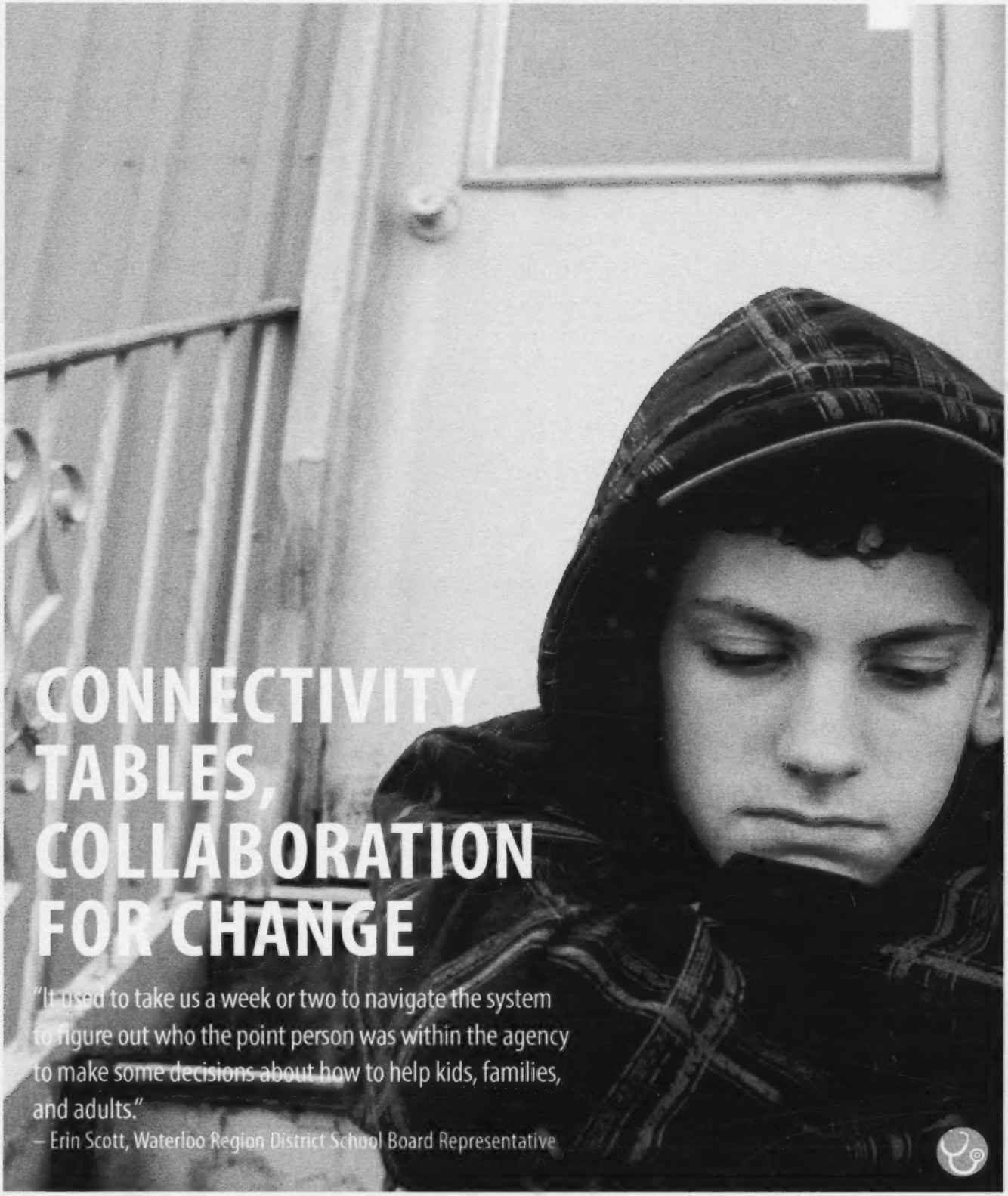
The support coordinator recognized that Luke and his family needed more health and social supports to manage Luke's health needs. The family did not have a primary care physician so the support coordinator connected the family with a Nurse Practitioner-Led Clinic to manage their care going forward.

The support coordinator also worked with Patty and the children to have them referred to a children's mental health program to address some of their own mental health concerns. Patty and Luke also received the help they needed to apply for funding from the Ontario Disability Support Program to help their family cope financially while Luke received the care and treatment he needed to get better.

"I think what makes the SCT program so successful is its approach to supporting people with mental health challenges," says Carmen Abel, Co-Chair at the steering committee for SCT. "Instead of people like Luke ending up in an emergency department, jail or worse, he is able to receive immediate support and is connected to the resources he needs. It's a much better outcome for Luke and for the health system."

Today, Patty, Luke, Mike and Lana are doing much better. The wrap around care from the Specialized Mobile Crisis Team initiative gave them the health care and social assistance they needed.

SCT NURSES MANAGED
699 INCIDENTS
IN 2014



CONNECTIVITY TABLES, COLLABORATION FOR CHANGE

"It used to take us a week or two to navigate the system to figure out who the point person was within the agency to make some decisions about how to help kids, families, and adults."

– Erin Scott, Waterloo Region District School Board Representative

MORE THAN HEALTH CARE: JOHN'S STORY

At the age of 11, grade 7 student, John, refused to go to school and was violent with his mother.

Local police were called to investigate and found much more than a troubled child. They found the home cluttered and unkempt, with no food in the fridge.

Upon speaking with John's mother, Mary, they learned she had accessed health and social services in the community yet she was not following through with her primary care plan and was not properly taking her medication.

Mary was also drinking heavily and she was sleeping for days at a time. Family members would often call 911 for assistance.

Because of his mother's state, John was not being cared for or fed regularly. John had also been missing school often and when he did attend, he required a teddy bear or another comfort item. John was clearly struggling with his own mental health concerns and, in addition to being aggressive, he expressed hatred for his mother and had suicidal thoughts.

Officers knew that this family needed a collaborative response that incorporated the services of multiple agencies.

Years ago, getting support from all these agencies would have been time consuming and difficult for Mary and John. However, in 2014, the Waterloo Wellington LHIN partnered with the Waterloo Regional Police Service, the Ministry of Community Safety and Correctional Services and Langs Community Health Centre to establish a Connectivity Table in Cambridge.

Based on successful programs in Prince Albert, Saskatchewan, Connectivity Tables bring together representatives from across all public service agencies to build on and enhance collaborative relationships in the community and develop early intervention strategies for at-risk residents.

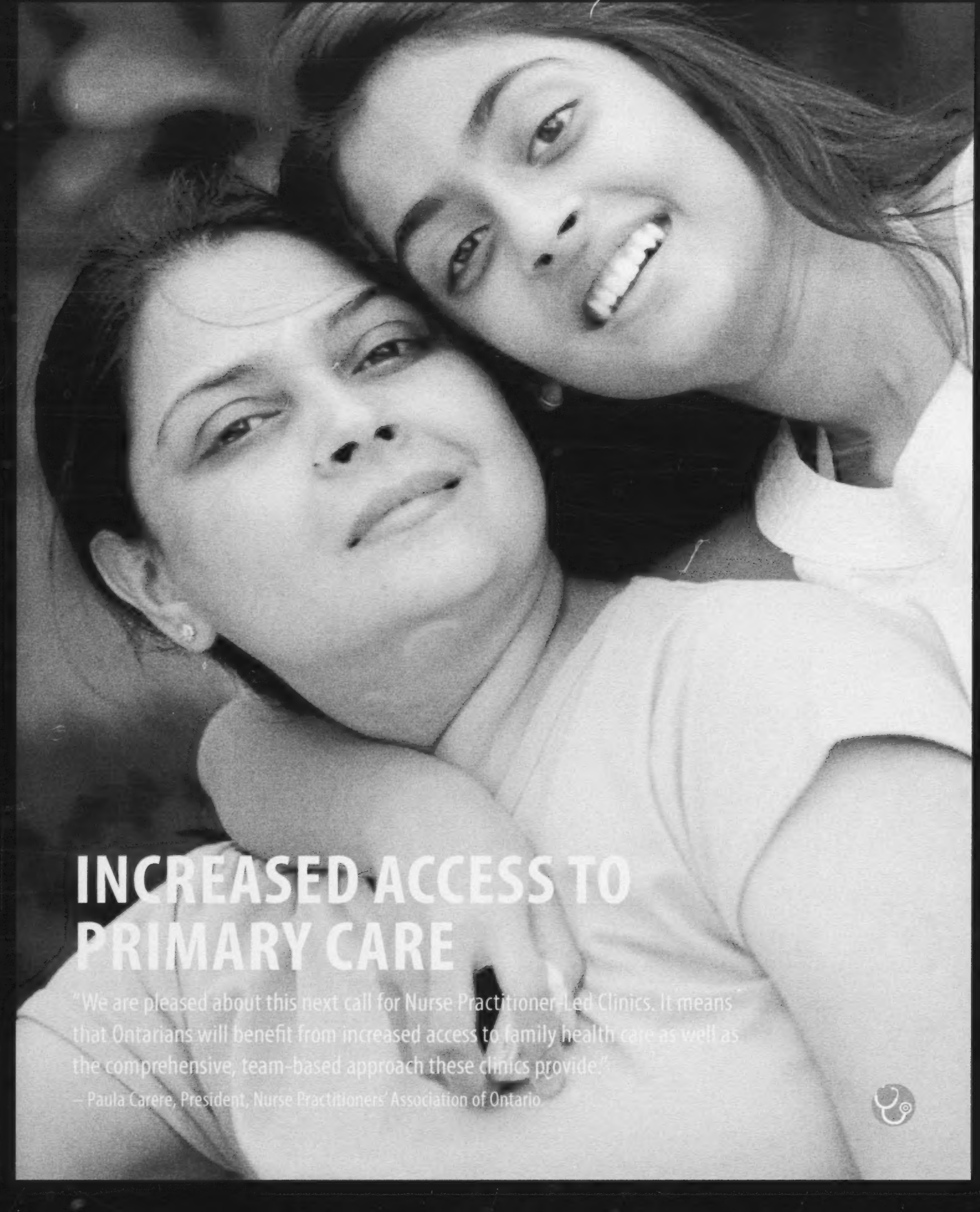
Mary and John's story was brought forward to the Connectivity Table. After a seven minute conversation, the Connectivity Table members put a plan in place to address risk factors of mental health, school attendance, parenting, physical health and addiction and within 48 hours that plan was acted upon.

- A mental health worker met with Mary, coordinated her admission to a hospital and linked her with alcohol treatment and counseling. A care plan was developed and was shared across agencies.
- Family and Children's Services addressed John's immediate needs for care. With Mary's consent, they placed John in a foster home temporarily while his mom worked on her mental health and on parenting issues. The school ensured that John had adequate supports while going through this transition.
- When John does return to Mary's care, issues of housing, employment and other long-term supports will be determined.

Without Connectivity Tables, Mary's condition would likely have deteriorated – increasing the complexity of her care and John's immediate needs for support may have been missed.

SINCE ITS INCEPTION
159 CASES
HAVE BEEN RESOLVED THROUGH
CONNECTIVITY TABLES

YouTube Check out our Connectivity Table story online: TheWWLHIN



INCREASED ACCESS TO PRIMARY CARE

"We are pleased about this next call for Nurse Practitioner-Led Clinics. It means that Ontarians will benefit from increased access to family health care as well as the comprehensive, team-based approach these clinics provide."

– Paula Carere, President, Nurse Practitioners' Association of Ontario

PRIMARY CARE INNOVATION: ANJI'S STORY

Anji is a 50-year old single mother of three who recently immigrated from Pakistan. She was having difficulty finding the right family doctor to help her manage her diabetes, anxiety and depression. Her anxiety and panic attacks became so debilitating she frequented the emergency department of a local hospital. As a new immigrant to Canada, language barriers increased her anxiety and depression.

She came to the Waterloo Region Nurse Practitioner -Led Clinic (WRNPLC) anxious and frustrated. With help from an interpreter, the clinic learned of Anji's chronic history of diabetes, anxiety and depression. She confided that she had not been taking her medication or having lab work done on a regular basis. A complete assessment was done by the nurse practitioner (NP) who then involved a registered practical nurse (RPN), pharmacist, social worker and dietician in Anji's care. The team created a coordinated care plan that clearly outlined what steps should be taken to manage her care. The NP arranged for her blood work to be done and the social worker provided emotional support and arranged for the plan to be communicated to Anji in her own language.

Anji started taking her medication and following her care plan and was able to see a mental health professional through the Ontario Telemedicine Network (OTN).

Today, Anji is doing well. She is managing her diabetes through diet, medication and regular check-ups. She is better able to deal with her anxiety and knows where to go for help when she needs it.

Her 14-year old daughter, Amina, is happy with the care and support her mom has received and says, "my mom no longer goes to the ER since becoming your patient."

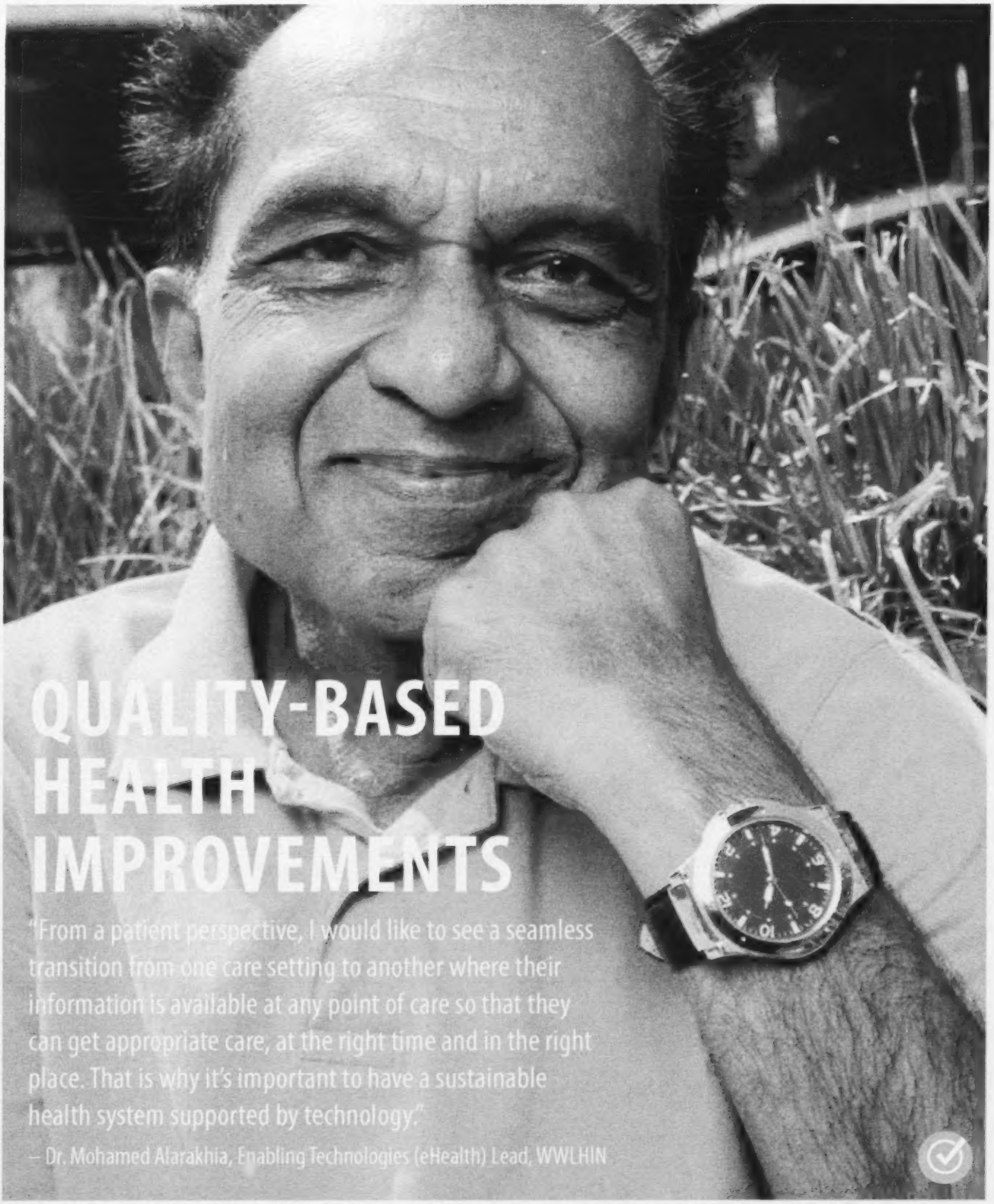
Primary care providers are an anchor for people within the broader health and social services system. They help people maintain healthy lifestyles, recover from acute health conditions and manage chronic disease through monitoring, system navigation, assistance, education and screening.

While the majority of Waterloo Wellington residents have a family doctor, there are some who do not. To address this gap, the Province introduced nurse practitioner lead clinics as a new delivery model for primary care.

In Waterloo Wellington, the WRNPLC operates out of two locations (Kitchener and Cambridge). Since 2012, the clinic has welcomed 2,865 residents into their primary care practice and continues to accept new patients.

THE WATERLOO REGION NURSE PRACTITIONER LED CLINIC HAS SEEN

2,865 NEW PATIENTS SINCE 2012



QUALITY-BASED HEALTH IMPROVEMENTS

"From a patient perspective, I would like to see a seamless transition from one care setting to another where their information is available at any point of care so that they can get appropriate care, at the right time and in the right place. That is why it's important to have a sustainable health system supported by technology."

– Dr. Mohamed Alarakhia, Enabling Technologies (eHealth) Lead, WWLHIN

IMPROVING HEALTH COMMUNICATION: KARL'S STORY

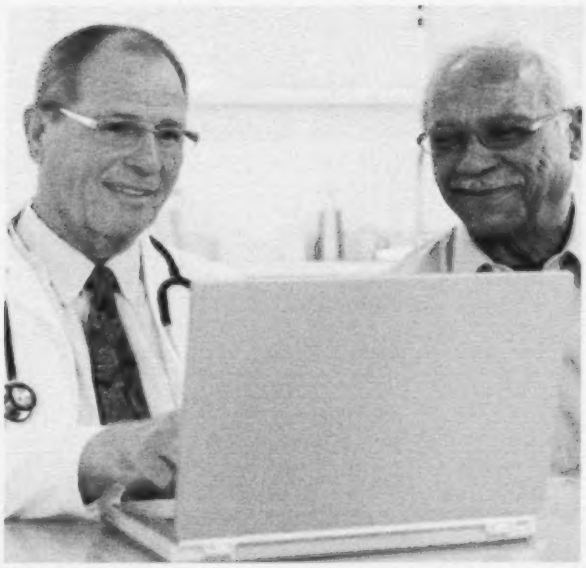
77-year old Karl lives in Kitchener. He is a widower and has two grown children and four grandchildren. He enjoys visits with his family when he's well enough to leave his apartment or have visitors drop by. He has congestive heart failure, kidney disease and diabetes. He has good days and bad.

When Karl visits his family doctor, she, and the team that works with her, not only address his health concerns but also discuss preventative care with Karl.

By using the best practice templates in the electronic medical record provided by Project QBIC (Quality Based Improvements in Care), Karl's family doctor is able to determine appropriate preventative treatments, such as vaccinations for things like pneumonia, which can prevent unnecessary illness and visits to the emergency department and hospitalization.

Project QBIC also provides tools that allow Karl's care team to identify lab tests that should be done within the best practice time. For Karl, that means a reminder comes up in his electronic medical record that prompts his doctor to send him for blood tests to check his kidney function even though that was not the purpose of his visit on that day. Because Karl has difficulty remembering things like medical appointments, his doctor's office schedules a reminder phone call to Karl several days before his appointment so he doesn't miss it.

The technology also guides physicians to consider a patient's complex needs when making decisions about appropriate medications. For example, a few months after his last visit, Karl returned to his doctor complaining of joint pain. The doctor diagnosed his condition as gout. Through the information in his EMR, she was able to determine that Karl could not take the medication that is regularly prescribed for gout because it could affect his kidney function. Good primary care and electronic medical records prevented Karl from getting a medication that could have made his kidneys worse.



REVOLUTIONIZING MEDICINE THROUGH TECHNOLOGY

You can go back to 1895, when German Physicist Wilhelm Röntgen was credited with discovering X-rays, to see how much technology has changed the way doctors diagnose and treat their patients. Today, technology is still revolutionizing medicine to ensure patients are getting the right care, at the right time, in the right place.

Recently, the eHealth Centre of Excellence (eCE) was recognized through a 2015 National Leading Practice Initiative that explores how EMRs can be used in clinical environments to help health professionals improve their quality of care and deliver more efficient and targeted care to their patients.

Locally, this initiative is helping residents like Karl.

4,000 WATERLOO WELLINGTON
CLINICIANS AND STAFF
CURRENTLY USING
ELECTRONIC MEDICAL RECORDS

PALLIATIVE CARE: KAREN'S STORY

Karen was a 40-year old recently widowed woman who was diagnosed with kidney cancer in the spring of 2012. There were limited treatments available for her cancer and prognosis for her advanced disease was not good. The Hospice of Waterloo Region received a call from the school social worker at the end of September 2012, when Karen's six-year old son was found to be missing school on a regular basis. Karen was living alone in a small apartment and her disease had advanced to such a point that walking more than a block would render her out of breath and dizzy. She could drive her son to school, but in order to drive she had to refrain from taking her pain medication.

Karen was a private person and fiercely independent. She knew that she was dying but was continually hopeful that she would live until the end of the school year. After a worker from The Hospice of Waterloo Region reached out to her, Karen agreed to have a volunteer visit weekly and to accept assistance with tasks like shopping.

As she grew to trust the staff at the hospice, she asked for information on funeral arrangements for someone with no income and for counsel on what documents would be necessary for her to have her 22-year old daughter become her son's guardian upon her death.

Even though Karen did not want to talk about dying, staff at the Hospice were able to offer counseling to Karen's daughter who was overwhelmed by the prospect of her mother's death and becoming a parent to her little brother.

Counseling in this situation was intense over a short period of time to stabilize a situation that was changing on a weekly basis. Referrals to other community services for her daughter were made to assist her with managing her new situation.

To support people like Karen, the Waterloo Wellington LHIN has invested $1.2 million over three years to Hospice of Waterloo Region to develop an Advance Care Planning Program in Waterloo Wellington. As a result, more residents will have support in preparing for their end-of-life care.

OUR PROGRESS

Under our three priorities, we have established key initiatives to improve the local health system. We have also identified performance indicators that demonstrate the progress towards our goals. The targets outlined here are guided by the goal of providing the highest quality health system for our residents and are based on provincial targets or on what clinical evidence suggests results in the best outcomes for residents, whichever is better.

STRATEGIC PRIORITIES FOR OUR LOCAL HEALTH CARE SYSTEM:

ENHANCING ACCESS TO PRIMARY CARE

CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED BEST PRACTICE

ENHANCING ACCESS TO PRIMARY CARE

25% MORE RESIDENTS WERE ABLE TO SEE THEIR **PRIMARY CARE PROVIDER** THE SAME OR NEXT DAY.

Your primary care provider is probably the first health care professional you will turn to for care. Primary care professionals are often family doctors but they may also be nurse practitioners or other health care professionals responsible for coordinating the specialized services required from other providers.

For primary care providers across the Waterloo Wellington LHIN to deliver the best care possible, it is important that they are well informed and connected with other health service providers and have access to technology that will assist them in providing the best care.

INITIATIVES

To meet our targets, we have broken down each priority into a set of system goals – specific action items that will help us and our health service providers achieve our objectives.

GOAL

Through Health Links, establish individualized, coordinated care plans for high needs residents across Waterloo Wellington.

ACHIEVEMENT

Health Links are a provincial, transformative innovation that provide coordinated local care for high needs residents. Waterloo Wellington now has four established Health Links that cover the full geography of our LHIN.

Now, people with multiple health care concerns receive coordinated care plans that ensure their complex needs are met efficiently and that they receive the best possible care.

GOAL

Build partnerships between health, social services, education, justice and other community partners to improve population health.

ACHIEVEMENT

The Waterloo Wellington LHIN is leading the way in an all-of-community approach to supporting well-being. Partnering with the local police services, Connectivity Tables have been established across the LHIN. These groups bring together representatives from public service agencies like police, Family and Children's Services, crisis intervention, and health care to provide wrap around services to our residents who are at high risk – making more efficient use of health and social service resources.

See page 10 for John's Story.

Further partnerships between police services and the Canadian Mental Health Association have added mental health nurses to policing teams and helped to reduce the number of unnecessary hospital admissions for residents with mental health concerns.

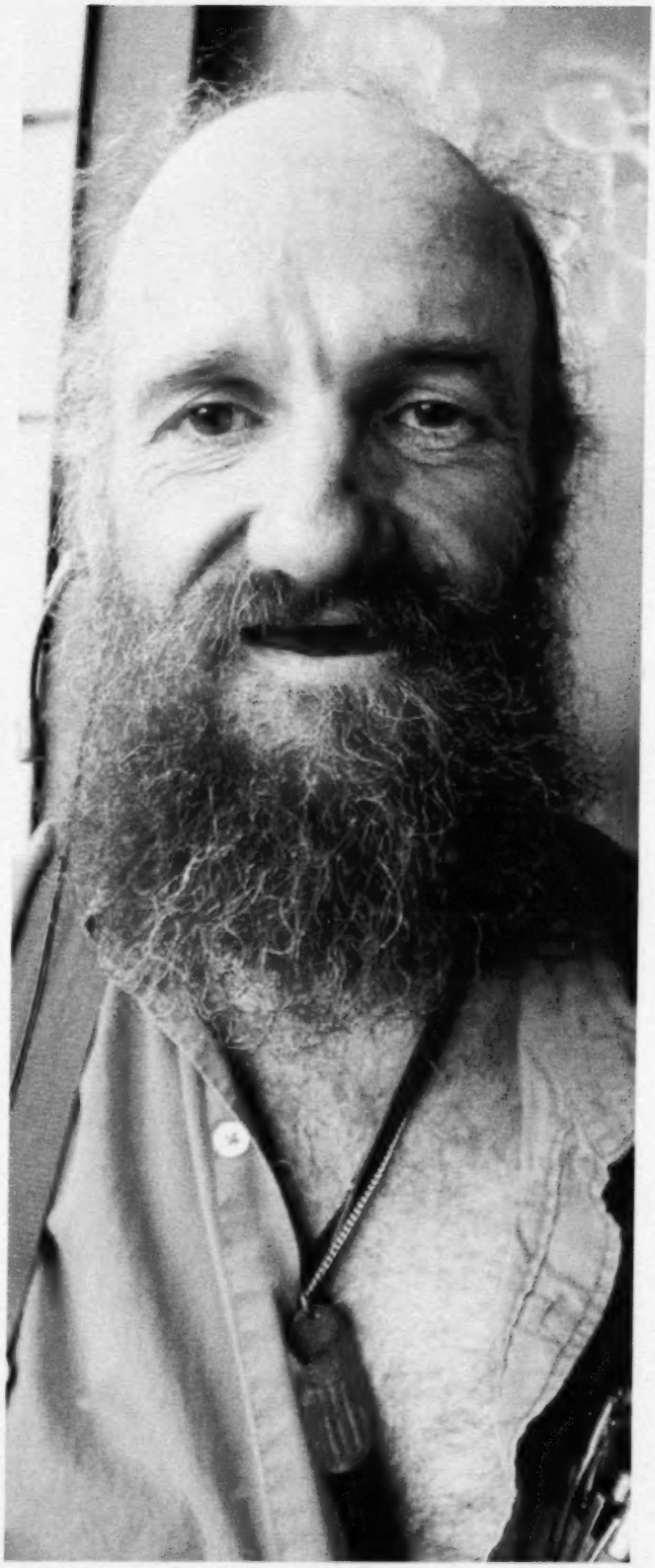
See page 8 for Luke's Story.

GOAL

Improve health equity through improved access to care close to home.

ACHIEVEMENT

Health equity means all of our residents have access



to the same quality of care – no matter who they are or where they live. Through our Telemedicine program, residents have access to doctors and other medical professionals via tele-conference. Last year, telemedicine connected almost 30,000 of our residents with the care they needed.

GOAL

Improve access and implement best practice guidelines for diabetes care and chronic disease prevention and management in Waterloo Wellington.

ACHIEVEMENT

In 2010, the wait times for care in the diabetes program were up to 16 weeks and the process was often confusing for residents. In 2014, we improved the way that we monitor wait times and, as a result, they have significantly improved. Now most patients will have an appointment within 28 days.

French-speaking residents are also now able to access programs such as Living Well with Diabetes in their own language, improving care and support.

GOAL

Implement enabling technologies including:

- Ontario Laboratory Information System (OLIS)
- Hospital Report Manager (HRM)
- Technology supporting Health Links

ACHIEVEMENT

Implementing new technology is extremely important in health care. The Hospital Report Manager (HRM) and electronic medical records (EMR) allow physicians to pass information between providers seamlessly and ensure residents are getting the right care at the right time.

This year, great progress has been made in developing these enabling technologies in the Waterloo Wellington LHIN including the development of electronic coordinated care plans and the roll out of HRM in our largest hospital. Over the next year, HRM will be implemented in the LHIN's other hospitals.

98% OF RESIDENTS HAVE A PRIMARY CARE PROVIDER

HOW WE'VE MADE THINGS BETTER: *HEALTH LINKS*

THEN:

Mario was a 71-year-old single male living with diabetes and dementia. He didn't have a primary care provider and he frequently had to visit the emergency department (ED) because of diabetes complications as he didn't remember to take his medication.

NOW:

Through the ED and the Health Links initiative, Mario was identified as a high-needs resident who required wrap around care to manage his complex conditions. Health Links and the Health Care Connect Program then connected him with a physician in his area. The ED staff also referred Mario to a local diabetes education program where he is learning how to better manage his diabetes. Health Links partners also ensured he had the appropriate wrap-around care from various providers, including a personal support worker who supports Mario on a daily basis, to make sure he is appropriately managing his conditions. Mario has not had any diabetes complications for the last year and hasn't been to the ED since he was referred to the education program.

CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

WAIT TIMES FOR GERIATRICIANS REDUCED BY UP TO 75%

A key aspect of a quality health system is ensuring residents get the right care, at the right time, in the right place. Easily navigating the health system is particularly important for those with the most complex health care needs.

Seamless care occurs when residents can transition from one area of care to another easily. A well coordinated system means you don't have to repeat your story and you will know where to go to find the help you need.

INITIATIVES

To meet our targets, we have broken down each priority into a set of system goals – specific action items that will help us and our health service providers achieve our objectives.

GOAL

Expand and improve upon streamlined, coordinated access to services across the continuum of care.

ACHIEVEMENT

Alongside our mental health service partners, we have transformed the way residents access mental health services in Waterloo Wellington. With a single call to the Here 24/7 crisis line, residents are now connected to referrals, counseling and support services throughout the system.

Great work has also been done with our Community Health Centres to centralize diabetes education to make resources more consistent and easier for residents to find.

Over the next year, we are going to grow and connect these and even more services to improve, coordinate and further streamline the system.

GOAL

Strengthen and maximize the current quality & capacity of community services.

ACHIEVEMENT

With a focus on efficiency and providing as much support as possible, several community support agencies have made strides towards integrating and collaborating to expand services. For example, in 2014 the Alzheimer's Societies of Cambridge, Guelph-Wellington and Kitchener-Waterloo amalgamated to form the Alzheimer's Society of Waterloo – Wellington. The integration allowed the society to expand their existing programs to serve more residents.

Numerous one-time investments have also been made in other community supports. These investments include financing hearing technology and investing in the quality and service delivery efficiency of meals on wheels and transportation services across the LHIN.

GOAL

Remove barriers for people waiting for an alternate level of care.

ACHIEVEMENT

We are continually assessing and measuring how well the health system is managing alternate level of care (ALC) patients. These are patients who no longer need to be in the hospital but are waiting to move to another facility or back home with support. Over the past year,

we have expanded programs that keep people from being admitted to the hospital through initiatives such as rapid response nursing teams. Through investments into enhanced supports for palliative care, mental health and addictions services and complex continuing care and long-term ventilation, we have increased the capacity in the system to manage patients in the most appropriate place.

GOAL

Improve care for seniors through implementing key recommendations of the Provincial Seniors Strategy.

ACHIEVEMENT

Community-based nurse practitioners, including mental health nurses specializing in providing care to seniors, are now available to increase services for geriatric patients and reduce the number of referrals to geriatricians so that these specialists see the most complex cases.

Waterloo Wellington was chosen to pilot the Assessment Urgency Algorithm tool. The screening tool helps providers identify the seniors who may need additional assessments or who may be at increased risk of declining health.

We've also supported the development of two new electronic learning modules on geriatric addictions and heart failure aimed at supporting providers in their ability to recognize, assess and treat these conditions in seniors and increase their ability to take on more patients.

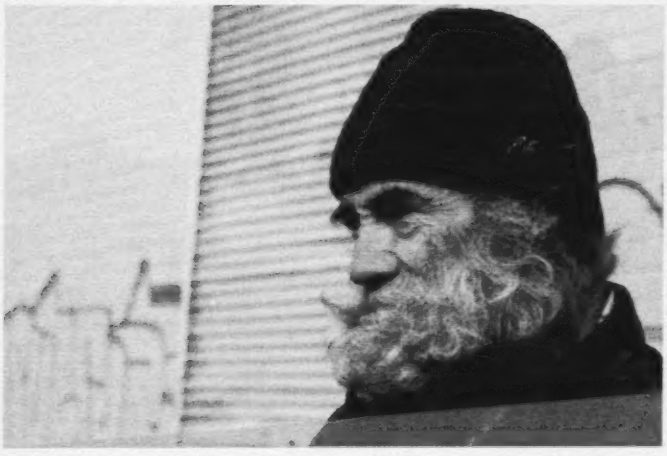
GOAL

Improve the quality and safety of care in long-term care homes.

ACHIEVEMENT

The Waterloo Wellington LHIN invested $621,000 into behavior supports in long-term care. As a result, more seniors are able to access long-term care services and fewer seniors are ending up in the emergency department due to injuries caused by behavioural issues.

See page 6 to read Noreen's Story.



HOW WE'VE MADE THINGS BETTER: *COORDINATED CARE*

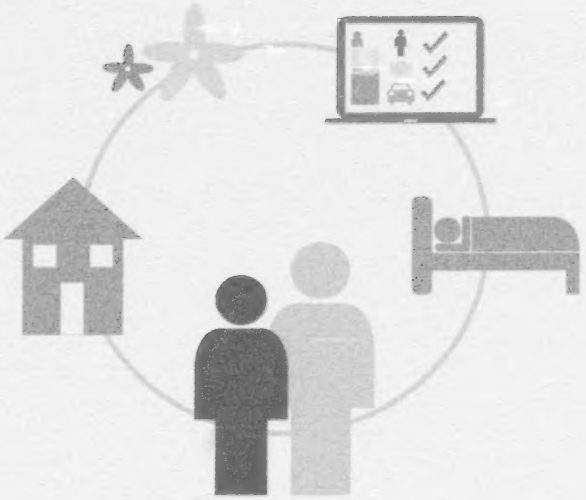
THEN:

Abdul, a 55 year old male, was living with his mother who was no longer able to take care of herself as she had developed dementia. Abdul had to quit his full-time job and find part-time work so that he had time to take care of his mother. Abdul's mother became ill with pneumonia and was admitted to the hospital where she had to stay because Abdul was unable to provide the level of care she needed in their home.

NOW:

Through a hospital referral to the Community Care Access Centre, Abdul's mother was assigned a care coordinator and she was assessed and approved for in-home personal support worker services. Abdul's mother was able to leave the hospital and have a support worker help her right away in her home.

The care coordinator was able to use an online tool to book services to ensure that Abdul's mother could have meals delivered to her home, friendly visits and home help, transportation to medical appointments and registration for community Alzheimer and dementia programming. The care coordinator was also able to refer Abdul to a respite bed when he needed a break. With his mother receiving care in the home, Abdul was able to increase the hours he worked and take some time for himself.



LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED PRACTICE

865,70 1 FEWER HOURS
WAITED IN THE EMERGENCY DEPARTMENT
FOR CARE SINCE 2008

Having access to quality care means that your care is safe, effective, accessible, equitable, efficient, integrated and focused on prevention as much as treating illness.

The best way to ensure our services meet those standards is to base our care on proven methods and ensure those methods are used consistently across the system.

Integrating care around patients and their families is at the core of what we do. Patients should be able to receive the same high quality of care regardless of where they are treated in Waterloo Wellington."

Bruce Lauckner, CEO, Waterloo Wellington LHIN

INITIATIVES

To meet our targets, we have broken down each priority into a set of system goals – specific action items that will help us and our health service providers achieve our objectives.

GOAL

Improve patient outcomes through the delivery of best practice care, at the best practice price, in alignment with province-wide Quality Based Procedures.

ACHIEVEMENT

Identifying evidence-based best practices is an important step in delivering a standardized quality of care. The Waterloo Wellington LHIN is working hard to implement clinical order sets across the system. Clinical order sets are conveniently grouped medical orders that work to standardize diagnosis and treatment following pre-established clinical guidelines. The order sets will increase the quality and efficiency of care provided to our residents.

GOAL

Implement new integrated programs which will include the establishment of a program sponsor and clinical councils for each program, identification of standards and care pathways and a move towards more equitable access and consistency of quality across Waterloo Wellington.

ACHIEVEMENT

The Integrated Diagnostic Imaging Program for Waterloo Wellington was implemented ahead of schedule. They are focused on reducing wait times for diagnostic imaging procedures.

Through the Integrated Wound Care Program, residents of Waterloo Wellington receive care from a wound care specialist using industry best practices that ensure quality and consistency across service providers.

Expand and enhance integrated programs that ensure quality and deliver best practice care across the continuum of care. Key improvements will include:

GOAL

Cardiac

- Identify and implement improvements including remote pace-maker monitoring trial

ACHIEVEMENT

The Remote Pacemaker Monitoring Program in Guelph has allowed more than 200 patients to have their routine pacemaker monitoring done closer to home, saving them up to two hours per visit.

GOAL

Critical Care

- Implement the provincial Life or Limb Policy across Waterloo Wellington
- Implement critical care High Performing Checklist

ACHIEVEMENT

The Life or Limb Policy is now fully implemented in the Waterloo Wellington LHIN. This allows critically ill residents to access the specialized care they require quickly. A repatriation policy has also been implemented that allows residents that were transferred to other facilities for specialized care to return to a hospital close to their home for recovery.

Supported by investments in patient order sets, the Critical Care Council has identified specific quality improvement initiatives for the coming year. The local framework will mean that all institutions work from a single standard for care.

GOAL

Emergency Department

- Implement best practices across the continuum of care to meet emergency department wait times
- Implement standardized care pathways (beginning with asthma & influenza)
- Implement best practices for patient triage

ACHIEVEMENT

For the past two years, Waterloo Wellington has had the lowest average length of stay times in the province for admitted patients. Through engagement with those who frequently use their local emergency departments, we have identified ways to provide better care in the community and reduce the number of unnecessary visits to the ED. We are also working hard with our hospitals to improve the triage process and provide better care for residents from the moment they walk into an emergency department.

GOAL

Hospice and Palliative Care

- Improve admission process
- Improve service delivery model to support clients at home

ACHIEVEMENT

Through the new e-shift program, Waterloo Wellington residents have more choice in their end-of-life care. The program, which allows up to four personal support workers to be supported by one RN has increased the CCAC's capacity to support residents who wish to die at home.

Read Karen's Story on page 15.

GOAL

Mental Health and Addictions

- Develop and implement service improvements based on the experience of high needs residents
- Improve youth addictions services
- Improve access to more effective mental health services for youth and young adults

ACHIEVEMENT

The Waterloo Wellington LHIN has made substantial investments to improve mental health and addictions services. In addition to Here 24/7, investments were made in local high priority services such as supportive housing, addictions-specific case management, community based eating disorder counseling and expanded mobile crisis teams. A monthly French Mental Health Café program is also now in place to address various mental health issues. These investments are helping provide coordinated care to residents with mental health and addictions concerns.

We are also partnered with Lutherwood and other agencies as a part of the Children and Youth Lead Agency Advisory Committee and are working on a plan for system change that will improve access to services for youth and young adults in the coming year.

Read Kourtney's Story on page 4.

GOAL

Rehabilitative Care

- Implement standardized patient pathways across sites

ACHIEVEMENT

Alongside the Acquired Brain Injury Steering Committee, we have worked to identify the current services available to those with acquired brain injuries and to develop a set of best practices for admission, provision of care and transition of care. This work will result in a fully coordinated system for those who need rehabilitative care as a result of acquired brain injuries.

GOAL

Surgery

- Design and implement an integrated access system for Orthopedic Surgery
- Develop and implement the Waterloo Wellington Vision Plan including possible community-based specialty clinics

ACHIEVEMENT

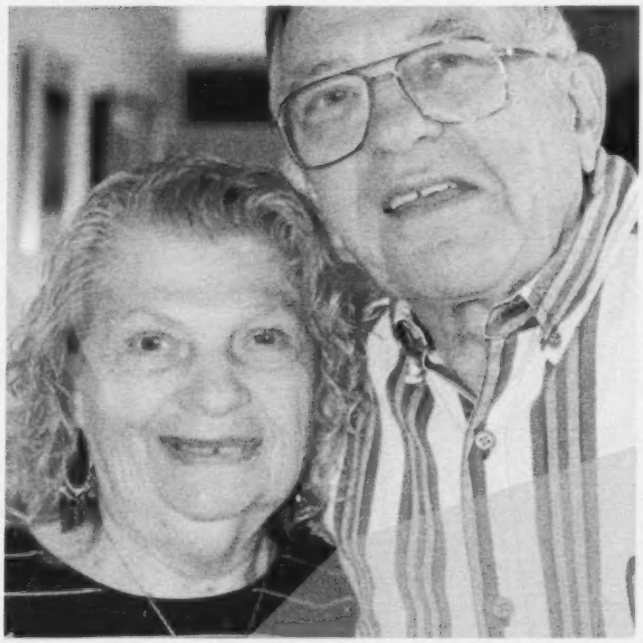
The Waterloo Wellington LHIN has allocated funding for hospitals to share wait times for orthopedic surgery, listed by surgeon, with primary care providers and patients. This means residents can make more informed choices about their care options.

The Waterloo Wellington LHIN has also developed a Vision Plan. The plan describes where the services are today and what changes we need to make to meet future needs.

In supporting Ontario's Wait Time Strategy, the Waterloo Wellington LHIN has reduced ED lengths of stay for patients requiring admission to hospital by 45 per cent and has reduced wait times for priority surgery and diagnostic imaging procedures by 64 to 81 per cent.

SHORTER WAIT TIMES	(IMPROVED BY*)
Emergency department stay for admitted patients: Down 45.2%	13.1 HRS
Non-urgent MRIs: Down: 74.6%	167 DAYS
Non-urgent CT scans: Down: 75.8%	100 DAYS
Hip replacements: Down: 64.1%	268 DAYS
Knee replacements: Down: 67.7%	334 DAYS
Cardiac by-pass surgery: Down 81.5%	119 DAYS

**This reflects improvements from the system starting point, i.e. when measurement started.*



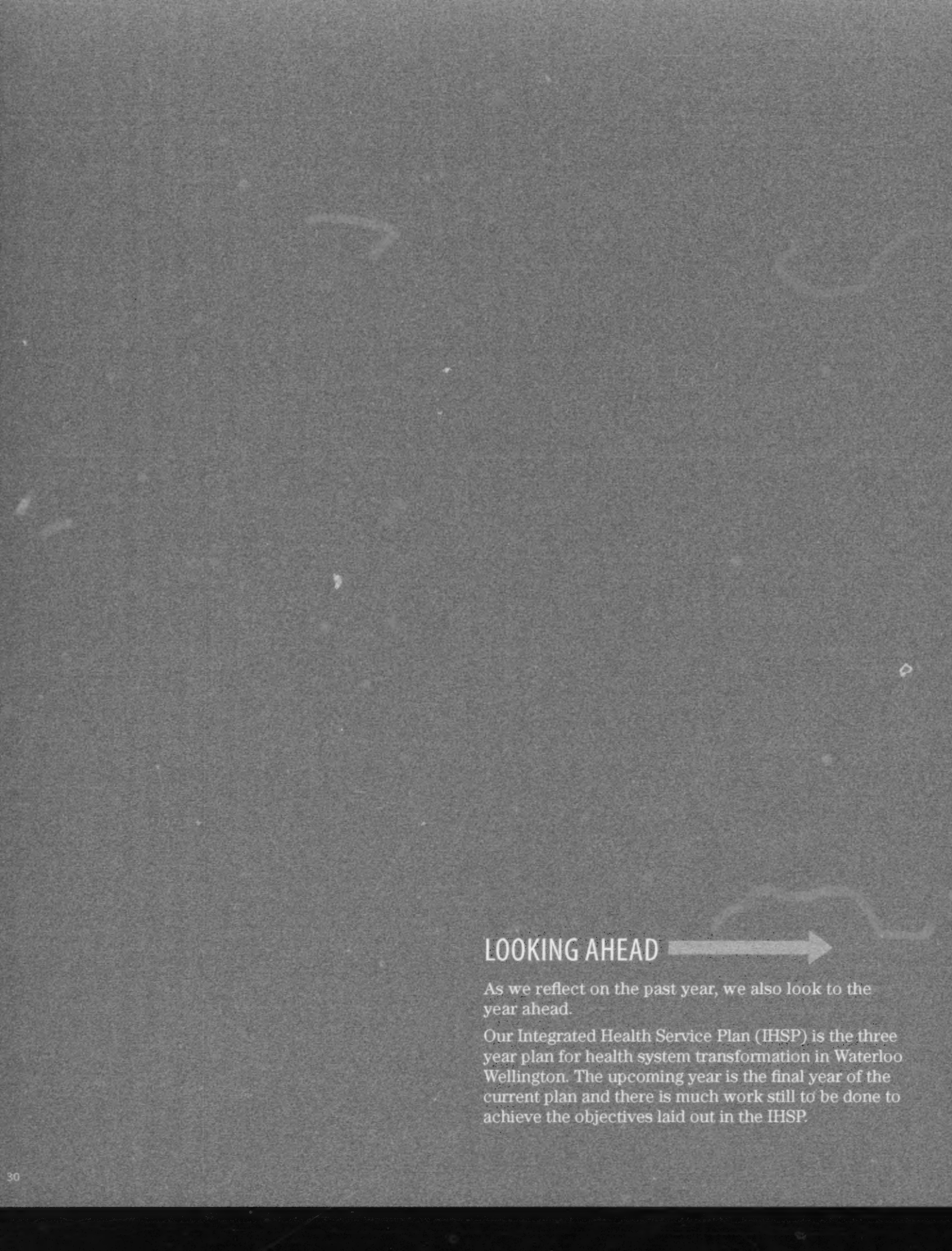
HOW WE'VE MADE THINGS BETTER: *STROKE CARE*

NOW:

Hanette is a 64-year old woman who has recently suffered a stoke. We know that getting patients to rehabilitation after a stroke will mean a better, faster recovery. A new professional stroke navigator is able to bring Hanette the right care, at the right time. The stroke navigator knows where each patient is within the stroke care system at any time. She has her eye on at least 50 patients on any given day, making sure each patient is getting the care they need quickly. She also works with each patient and their families to build plans that support them when they leave the hospital.

THEN:

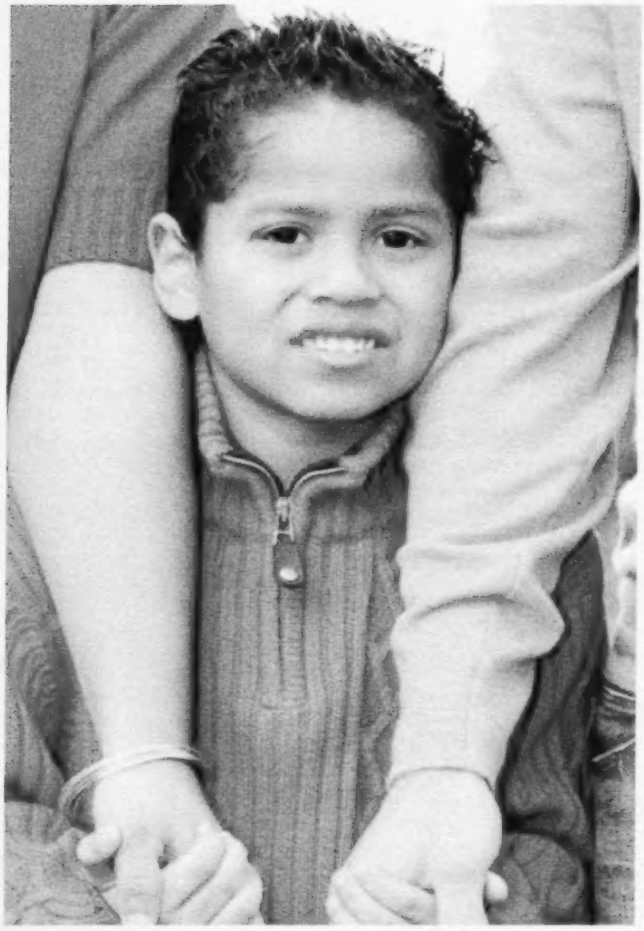
If Hanette had suffered a stroke a year or two ago, things would have been different. She would have received care, along with powerful clot-busting medication right away, but after she was admitted to hospital for care, she may have waited more than two weeks for a bed in a rehabilitation program.



LOOKING AHEAD

As we reflect on the past year, we also look to the year ahead.

Our Integrated Health Service Plan (IHSP) is the three year plan for health system transformation in Waterloo Wellington. The upcoming year is the final year of the current plan and there is much work still to be done to achieve the objectives laid out in the IHSP.



THE RAMOS FAMILY

The Ramos family lives in Cambridge. Anna (22) has two children, Miguel who is five and Mya who is three. Anna has stayed home since having Miguel and they live with her boyfriend Tyler (24) in an apartment. Tyler works in the manufacturing sector and money has been really tight supporting the four of them. However, his biggest stress is his mom, Maria.

Maria often sleeps on the couch in their tiny two-bedroom apartment. She lives with her boyfriend, an alcoholic who abuses her. When Maria stays with Tyler, her boyfriend will sometimes show up under the influence and threaten the family. When this happens, Anna packs up the kids and heads to her mom's house and Miguel misses school for a few days. Maria has turned to prescription painkillers for coping. She is unemployed and has Chronic Obstructive Pulmonary Disease (COPD) a chronic lung condition that makes it difficult to breathe.

HOW WE WILL BETTER CARE FOR THE RAMOS'?

The Ramos family's health needs are representative of many other families across Waterloo Wellington. Their needs, however, are not solely within the health care system. They require support from the education system, social support system, community safety services such as the police, employment services and more. How well they are supported by all of these sectors will impact their health far greater than health care services alone.

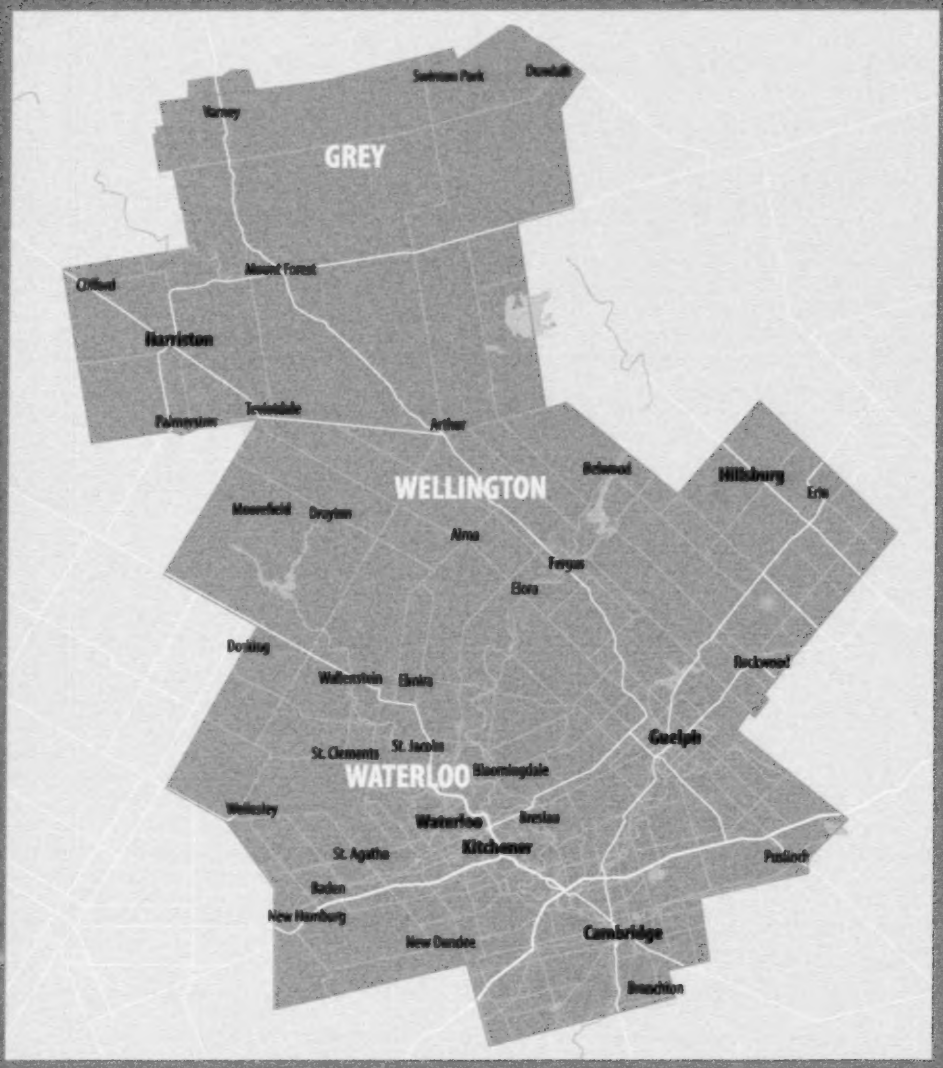
The Waterloo Wellington LHIN's strategy includes improving access to health care services for the Ramos' but it also reaches beyond, collaborating with other sectors to address the social determinants of health to improve their health and well-being. One example is Connectivity Tables – where all of our public service agencies come together to collectively identify individuals at elevated risk (like Maria) and work together to wrap supports around the entire family.

For a complete look at how the Waterloo Wellington LHIN is committed to improving your health in the next year, visit our website and read our Annual Plan. Here you will learn more about the Ramos Family and what steps we are planning to take to improve their health and the health of all of our residents.

ENGAGING OUR COMMUNITY

We take great care in listening to our residents to determine the necessary changes and improvements for our local health care system, and we'd love to hear your story of health in Waterloo Wellington. Contact us at waterloowellington@lhins.on.ca

Follow us on Twitter and Facebook or sign up for our newsletter through our website to get up-to-date information on what is happening in the local health system.



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Ontario
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